RESET

PROVIDENT LIFE AND ACCIDENT
INSURANCE COMPANY
CHATTANOOGA, TN 37402-1362
A subsidiary of UnumProvident Corporation

STATE OF TENNESSEE
OPTIONAL UNIVERSAL LIFE ENROLLMENT APPLICATION
☐ ANNUAL ENROLLMENT ☐ NEW HIRE

EMPLOYEE – MUST ALWAYS BE COMPLETED	**SPOUSE** – (Always show name-Fully Complete for Coverage)
NAME _____ Please Print (first) (middle) (last)	NAME _____ Please Print (first) (middle) (last)
_____ Residence Address (street/box no.)	_____ Residence Address (street/box no.)
_____ City State Zip	_____ City State Zip
Social Security Number _____ - _____ - _____	Social Security Number _____ - _____ - _____
Birthdate _____ Date of Hire _____ Sex ___	Birthdate _____ Sex ___
Budget Code _____ Daytime Phone No. _____	Has spouse been hospitalized, advised to seek medical treatment, or received disability benefits during the last 6 months? ☐ Yes ☐ No If yes, submit supplemental application.
Employee Annual Base Salary $ _____	
CERTIFICATE INFORMATION - EMPLOYEE	CERTIFICATE INFORMATION - SPOUSE
Employee Coverage Amount: $_____ Minimum - $5,000 Maximum - Five times your annual base salary, rounded to next higher multiple of $5,000 up to $300,000. Amounts over three times annual base salary subject to medical evidence of insurability.	Spouse Coverage Amount: $_____ Minimum - All Ages: $5,000 Maximum - Less Than Age 55: $15,000 or one times employee annual base salary in multiples of $5,000 up to $30,000. Maximum - Ages 55 and Over: $15,000
Children's Coverage: ☐ $2,500 ☐ $5,000 Coverage available on either employee or spouse certificate, but not both. However, if employee purchases coverage, children's coverage must be attached to that certificate.	Children's Coverage: ☐ $2,500 ☐ $5,000 Coverage available on either employee or spouse certificate, but not both. However, if employee purchases coverage, children's coverage must be attached to that certificate.
Beneficiary Relationship	Beneficiary Relationship
Address	Address

COMPLETE ONLY IF DEPENDENT CHILDREN'S TERM INSURANCE CHOSEN ABOVE.

List eligible dependent children as defined in the plan.

Child's Name (First) (Middle) (Last)	Social Security Number	Date of Birth Mo	Day	Year	Issue Age	Sex M or F	Relationship to Employee
	- -						
	- -						
	- -						

The beneficiary of children's term insurance is the employee, if living, otherwise the estate of the covered child.

I certify that the information on this application is true and complete and that I am Actively at Work/Positive Pay Status on the date of my signature below. I understand that if I have selected insurance for myself, it will begin on the Certificate Issue Date; provided I am Actively at Work/Positive Pay Status on that date.

Dependent Spouse and/or Dependent Children's Coverage, if selected, will begin on the Certificate Issue Date; provided: (1) I am Actively at Work/Positive Pay Status on that date; and (2) my Dependent Spouse and/or Dependent Child(ren) is/are able to engage in normal activities on the date the coverage is to become effective.

I understand that I, as the Employee, am the owner of all coverages applied for. I authorize my Employer to deduct the proper premiums for this insurance from my earnings.

Employee Signature_____ Date _____

FOR HOME OFFICE USE ONLY

DEDUCTION AMOUNT: E _____ S _____ C _____ TD _____

M-95090 (9/05)